

**DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
INTERPRETER SERVICE REQUEST/APPROVAL
FOR SPOKEN OR SIGN LANGUAGE**

Program Index G2421
Allocation Code 0010
DBHR Org Index G700

DBHR APPROVAL NUMBER

CONFIDENTIALITY REMINDER: Treatment Provider – REMOVE CLIENTS NAME BEFORE faxing this form to Interpreter vendor agency or broker (per Alcohol/Drug Federal Confidentiality Regulations, CFR 42, Part 2).

INTERPRETER VENDOR NAME: _____ If applicable, FAX Number: () - _____

Treatment Provider Name: _____	Phone Number: () - _____
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Treatment Provider Address: _____	Fax Number: () - _____
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Contact Person: _____

CLIENT INFORMATION

Client Name: _____
(Please print clearly) *Last* *First* *MI*

Client Date of Birth _____

Who referred this patient to you? _____

Language: _____

TREATMENT

Service Type/Modality: _____ What hrs. will treatment begin and end? _____

How many times each week? _____ Dates of Interpreters Svc: Begin _____ Thru _____

What is the source of payment for client's treatment?

- ☐ DBHR Direct Residential Contract
- ☐ DBHR/County Contract (Low Income) Contract Type: _____
- ☐ DBHR/County Medicaid Contract (TXIX) - ***MUST include client's Medicaid Coupon when faxing this form***
- ☐ Other, explain: _____
- ☐ Private Pay, or Insurance

DBHR USE ONLY

- ☐ APPROVED
- ☐ Not yet approved - Still needs the following information:
- ☐ Denied - Reason: _____

DBHR Approval: _____ (Date)	DBHR Approval: _____ (Signature)
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DBHR faxed to treatment provider: _____	Ronnie San Nicolas, DBHR Interpreter Services Coordinator Phone Number: (360) 725-1280 E-mail: sannirj@dshs.wa.gov Fax Number: (360) 586-0342
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